

<i>SERFF Tracking Number:</i>	<i>UNAM-127691779</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Constitution Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>50176</i>
<i>Company Tracking Number:</i>	<i>CL-LDBAPP (11) AR</i>		
<i>TOI:</i>	<i>L07I Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L07I.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Life App</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Filing at a Glance

Company: Constitution Life Insurance Company

Product Name: Life App

TOI: L07I Individual Life - Whole

Sub-TOI: L07I.101 Fixed/Indeterminate
Premium - Single Life

Filing Type: Form

SERFF Tr Num: UNAM-127691779 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 50176

Co Tr Num: CL-LDBAPP (11) AR State Status: Approved-Closed

Author: Julia Bryan

Date Submitted: 11/02/2011

Reviewer(s): Linda Bird

Disposition Date: 11/07/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 11/07/2011

State Status Changed: 11/07/2011

Created By: Julia Bryan

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Julia Bryan

Filing Description:

We are submitting the above referenced form for your review and approval. This form will replace our previously approved form CLA-LDBAPP (12/09) AR which was approved for use in your state on November 4, 2009 under State Tracking Number 43960.

The application CLA-LDBAPP (11) AR will be used to offer our Whole Life Insurance policy. This coverage will be marketed on a personal contact basis by our licensed agents.

We have bracketed as variable the office addresses and telephone numbers so they may be changed without

<i>SERFF Tracking Number:</i>	<i>UNAM-127691779</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Constitution Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>50176</i>
<i>Company Tracking Number:</i>	<i>CL-LDBAPP (11) AR</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Life App</i>		
<i>Project Name/Number:</i>	<i>/</i>		

resubmitting to the department.

We hope this form will meet with your approval. If you have any questions or comments, please feel free to contact me at (407) 444-4383, or by email at Jbryan@universalamerican.com.

Thank you for your time and consideration in this matter.

Sincerely,

Julia Bryan
Sr. Contract Analyst

Company and Contact

Filing Contact Information

Julia Bryan,	jbryan@universalamerican.com
1001 Heathrow Park Lane	407-444-4383 [Phone]
Suite 5001	407-995-8021 [FAX]
Lake Mary, FL 32746	

Filing Company Information

Constitution Life Insurance Company	CoCode: 62359	State of Domicile: Texas
1001 Heathrow Park Lane	Group Code: 953	Company Type:
Suite 5001	Group Name:	State ID Number:
Lake Mary, FL 32746	FEIN Number: 36-1824600	
(407) 995-8000 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	\$50.00 per form x 1 form = \$50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
---------	--------	----------------	---------------

<i>SERFF Tracking Number:</i>	<i>UNAM-127691779</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Constitution Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>50176</i>
<i>Company Tracking Number:</i>	<i>CL-LDBAPP (11) AR</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Life App</i>		
<i>Project Name/Number:</i>	<i>/</i>		
Constitution Life Insurance Company	\$50.00	11/02/2011	53405391

SERFF Tracking Number:	UNAM-127691779	State:	Arkansas
Filing Company:	Constitution Life Insurance Company	State Tracking Number:	50176
Company Tracking Number:	CL-LDBAPP (11) AR		
TOI:	L071 Individual Life - Whole	Sub-TOI:	L071.101 Fixed/Indeterminate Premium - Single Life
Product Name:	Life App		
Project Name/Number:	/		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/07/2011	11/07/2011

<i>SERFF Tracking Number:</i>	<i>UNAM-127691779</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Constitution Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>50176</i>
<i>Company Tracking Number:</i>	<i>CL-LDBAPP (11) AR</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Life App</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Disposition

Disposition Date: 11/07/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>UNAM-127691779</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Constitution Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>50176</i>
<i>Company Tracking Number:</i>	<i>CL-LDBAPP (11) AR</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Life App</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Application for Insurance		Yes

SERFF Tracking Number: UNAM-127691779 State: Arkansas

Filing Company: Constitution Life Insurance Company State Tracking Number: 50176

Company Tracking Number: CL-LDBAPP (11) AR

TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life

Product Name: Life App

Project Name/Number: /

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	CL-LDBAPP (11) AR	Application/ Enrollment Insurance Form	Revised	Replaced Form #: CL-LDBAPP (12/09) AR Previous Filing #: 43960	40.100	CL-LDBAPP 11 AR.pdf

APPLICATION FOR INSURANCE

Proposed Insured _____ Address _____ City _____ State _____ Zip _____ Social Security Number _____ Birth Date _____ Age _____ Birth State _____ Sex _____ Marital Status _____ Occupation _____ Height _____ Weight _____ Phone: Day (_____) _____ Evening (_____) _____	Complete only if Owner is not Proposed Insured Owner _____ Relationship _____ Birth date _____ Address _____ City _____ State _____ Zip _____ Social Security/Tax ID Number _____
Secondary Addressee Information When the insured or owner is age 64 or older, a copy of any notification of possible lapse will be sent to this person. Name & Address: _____	
Send premium notices to: <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Owner <input type="checkbox"/> Other (Give name/address in Special Requests)	
Face Amount \$ _____ Plan _____ Accidental Death <input type="checkbox"/> Yes <input type="checkbox"/> No	Modal Premium: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> PAC <input type="checkbox"/> Credit Card <input type="checkbox"/> Visa <input type="checkbox"/> MC (Check one) Modal Premium Amount \$ _____ Automatic Premium Loan <input type="checkbox"/> Yes <input type="checkbox"/> No
Beneficiary of the Proposed Insured (If split, please indicate percentages) Primary _____ Birth Date _____ Relationship _____ Contingent _____ Birth Date _____ Relationship _____	
Does the applicant own existing, in-force policies or contracts on the Proposed Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the required replacement form.	
Do you now or have you within the last year used tobacco products in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please explain: _____	
Section 1 - No Coverage Available If the applicant answers "Yes" to any question in this section, the proposed insured is not eligible for coverage.	
1. Is the Proposed Insured currently: <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> a. hospitalized, bedridden, confined to a nursing facility, receiving hospice care, confined to a wheel chair due to disease, or received or awaiting an organ transplant?..... b. diagnosed with or being treated for a terminal illness?..... </div> <div style="width: 10%;"> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No </div> </div>	
2. Has the Proposed Insured ever been diagnosed with, treated for or been advised by a physician to be treated for Alzheimer's Disease, Dementia, Memory loss, ALS (Lou Gehrig's Disease)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Has the Proposed Insured ever tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. In the past 5 years, has the Proposed Insured been diagnosed with, treated for, or been advised by a physician they may have: <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> a. Congestive Heart Failure?..... b. Cancer, Malignancy, Leukemia, Melanoma, Lymphoma, Hodgkin's disease?..... </div> <div style="width: 10%;"> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No </div> </div>	
5. In the past 12 months, has the Proposed Insured had been diagnosed with, treated for or been advised by a physician to be treated for: <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> a. Heart Attack, Angina (chest pain), Angioplasty, Heart Surgery, Stent Placement, Stroke or Aneurysm?.. b. Kidney Dialysis, Alcohol or Drug Abuse/Dependency ?..... </div> <div style="width: 10%;"> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No </div> </div>	
Special Requests: _____	Administrative Office Use Only: _____

(Please complete reverse side)

6. In the past 24 months has the Proposed Insured ever been diagnosed with, treated for or been advised by a physician to be treated for:
- a) Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Pulmonary fibrosis, Chronic Asthma, Chronic Bronchitis or any other Chronic Respiratory Disorder?..... ☐ Yes ☐ No
- b) Parkinson's Disease, Muscular Dystrophy, Kidney Disease/Kidney Failure, Cirrhosis, or other Liver Disease, Sickle Cell Anemia?..... ☐ Yes ☐ No
7. In the past 24 months, has the Proposed Insured been diagnosed with, treated for or been advised by a physician to be treated for:
- a) Heart Attack, Angina (chest pain), Pacemaker/Defibrillator placement, Heart Surgery, Stroke, Aneurysm or other Heart or Circulatory disorder?..... ☐ Yes ☐ No
- b) Alcohol or Drug Abuse/Dependency?..... ☐ Yes ☐ No
- c) Diabetes requiring insulin or Diabetic Coma?..... ☐ Yes ☐ No
8. Is the Proposed Insured currently Paralyzed or has the Proposed Insured had an Amputation due to disease or disorder?..... ☐ Yes ☐ No
9. In the past 12 months has the Proposed Insured used Oxygen Therapy to assist in breathing?..... ☐ Yes ☐ No

I hereby apply for the insurance indicated above and I am submitting the first premium. The statements on the application are true to the best of my knowledge and belief. I understand that my policy will be effective on the date it is issued by the company except as stated in the conditional receipt. I personally completed the questions in Section 1 & 2 above.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the MIB, Inc., a pharmaceutical database or any other organization, institution, or person that has any records or knowledge of me or my health or that of any member of my family to give to Constitution Life Insurance Company or its reinsurers any such information. A photographic copy of the authorization shall be valid as the original. This authorization is valid for 24 months from the date of signature. It may be revoked at any time by sending written request to the Executive Office of Constitution Life Insurance Company. Revocation is subject to the rights of any person that acted in reliance on the authorization prior to receiving the revocation. **I the undersigned applicant acknowledge that I have read, or had read to me, the completed application. I realize that any false statement or misrepresentation made therein, that is material to the risk or hazard assumed, may result in loss of coverage under this policy.**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Cash paid with application \$_____.

Dated at _____, this _____ day of _____, _____.

X _____ X _____
Signature of Owner (if other than Proposed Insured) Signature of Proposed Insured

Instructions to agents - This statement must be completed with application.

1. Submit all applications and business transmittals within 7 days of application date.
2. Do not solicit business on any individual currently hospitalized or confined to a nursing home.
3. Do not solicit business on any individual you have reason to believe is suffering from a terminal illness.
4. All premium checks must be made payable to Constitution Life Insurance Company.
5. The full initial premium must be submitted with application.

Agent's Statement

By signing below, I the agent, hereby certify that all the information contained on this application has been truly and accurately recorded as supplied by the Proposed Insured. To the best of my knowledge all the answers are complete and true, and the applicant is not currently hospitalized or confined to a nursing home, nor do I have reason to believe the applicant is suffering from a terminal illness. The applicant has read or had read to him/her the entire application. To the best of my knowledge and belief the applicant does ☐ does not ☐ own existing, in-force policies or contracts on the Proposed Insured. I personally did see ☐ did not see ☐ the applicant at the time of the application.

Agent Printed Name _____ Agent Signature _____

Agent Number: _____ Agent State ID Number: _____

SERFF Tracking Number:	UNAM-127691779	State:	Arkansas
Filing Company:	Constitution Life Insurance Company	State Tracking Number:	50176
Company Tracking Number:	CL-LDBAPP (11) AR		
TOI:	L071 Individual Life - Whole	Sub-TOI:	L071.101 Fixed/Indeterminate Premium - Single Life
Product Name:	Life App		
Project Name/Number:	/		

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: READABILITY CERTIFICATION - AR.pdf		
Bypassed - Item: Application Bypass Reason: This is an application filing - See form schedule tab Comments:	Item Status:	Status Date:
Bypassed - Item: Life & Annuity - Acturial Memo Bypass Reason: Not Applicable - This is an application only filing. Comments:	Item Status:	Status Date:

READABILITY CERTIFICATION

Filing for: Constitution Life Insurance Company
P.O. Box 13547
Pensacola, Florida 32591

FORM NUMBER	FORM NAME	FLESCH SCORE
CL-LDBAPP (11) AR	Application for Insurance	40.1

I certify that the Flesch Reading Ease Score(s) for the above form(s) is/are true and correct.

**Michelle
Doherty**

Digitally signed by Michelle Doherty
DN: cn=Michelle Doherty, o=Universal
American, ou=Product Filing & Compliance,
email=mdoherty@universalamerican.com,
c=US
Date: 2011.11.02 13:47:25 -04'00'

Michelle Doherty
Vice President, Product Filing Compliance
November 02, 2011